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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31583**

Registration District No. **104**

Primary Registration District No. **3008**

Registrar's No. **228**

1. PLACE OF DEATH:  
(a) County **Callaway**  
(b) City or town **Fulton**  
(c) Name of hospital or institution **827 Westminister Ave**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2**  
(Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Callaway**  
(c) City or town **Fulton**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **827 Westminister**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

In this community \_\_\_\_\_ years, months or days  
3. (a) PRINT FULL NAME **Willard Gross**  
3. (b) If veteran, name war **No**  
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Sept.** day **10**  
year **1940** hour **2** minute **0** A.M.

5. Color or race **Male Negro**  
6. (a) Single, widowed, married, divorced **Divorced**  
6. (b) Name of husband or wife **Lila Ella**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Jan 6 1887**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Apr. 8**  
\_\_\_\_\_, 19\_\_\_\_, to **Sept. 6**, 19\_\_\_\_  
that I last saw him alive on **Sept. 6**, 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death **Myocarditis**  
**Valvulitis (chron.)**

8. AGE: Years **53** Months **1** Days **6**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions **Myocarditis**  
(Include pregnancy within 3 months of death)

9. Birthplace **Missouri**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Laborer**

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

MOTHER FATHER  
11. Industry or business **9**  
12. Name **James Gross**  
13. Birthplace **D.K.**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Emma Saller**  
15. Birthplace **Missouri**  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

16. (a) Informant **Edward Gross**  
(b) Address **Fulton, Mo**  
17. (a) **Burial** (b) Date thereof **Sept 12-40**  
(Special cremation or disposal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Callaway Co, Mo**  
18. (a) Signature of funeral director **Eli Beel**  
(b) Address **Fulton, Mo**  
19. (a) **9/12/40** (b) **R. N. Crum**  
(Date received local registrar) (Registrar's signature)

10 <sup>1/4</sup>  
While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
23. Signature **M. A. Archonson** (M. D. or other)  
Address **Fulton, Mo**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

Registered Apprentice No.

working under my personal supervision.

Signed

*Eli Bee*

Licensed Embalmer No.

*2130*

P. O. Address

*Fulton, Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**